

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-046143

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11621

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

USE BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin Desloge Hospital		d. STREET ADDRESS (If outside, give location) 1928 Hereford	
3. NAME OF DECEASED (Type or print) First Middle Last Josephine Turminia		4. DATE OF DEATH Month Day Year November 22, 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/15/1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11a. FATHER'S NAME Joseph Murano		11b. MOTHER'S MAIDEN NAME Unavailable	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		12b. SOCIAL SECURITY NO.	
13a. NAME OF HUSBAND OR WIFE George Turminia		13b. ADDRESS Mary Turminia, 1928 Hereford	
14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric A. Thrombosis DUE TO (b) Arterio-sclerotic C.V.R. Disease DUE TO (c) 442X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 day 54'	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from Jan 1962 to Nov 20, 1963 and last saw her alive on Nov 20, 1963 Death occurred at 1:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Theresa L. Leveils M.D.	
22b. ADDRESS 1931 Marconi		22c. DATE SIGNED 11/22/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-25-63	
23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION (City, town, or county) St. Louis Co., Mo.	
24. FUNERAL DIRECTOR Calcaterra Funeral Home, 5142 Daggett Ave.		25. DATE RECD. BY LOCAL REG. NOV 25 1963	
26. REGISTRAR'S SIGNATURE Paul Smith, M.D.			

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*[Handwritten Signature]*

Licensed Embalmer No. 3453

P. O. Address St. Louis, Mo.

**Note:** The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.